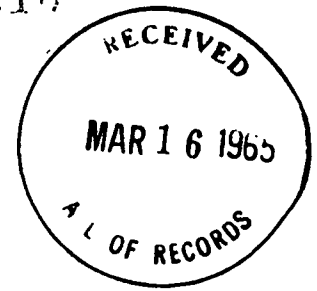


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REPORT  
BY GOVERNOR'S COMMISSION  
TO STUDY THE SHORTAGE  
OF GENERAL PRACTITIONERS IN THE STATE OF MARYLAND

including

CONCLUSIONS AND RECOMMENDATIONS

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#### MEMBERS OF COMMISSION

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Mr. Harry A. Dundore, Sparks  
Representative, General Public

Charles F. O'Donnell, M.D., Chairman, Towson  
Representative, Medical and Chirurgical Faculty of the State of Maryland

As a result of the passage of Senate Joint Resolution No. 9, introduced by Senator Harry Hughes in the 1964 session of the Maryland Legislature, a Commission was appointed by Governor Millard J. Tawes "to study and report on the acute problems resulting from a shortage throughout many parts of Maryland of general practitioners in medicine." The Commission was ordered to report its findings and recommendations to the Governor and to the Legislators of the 1965 Session of the General Assembly.

This Commission, as proposed by the General Assembly and appointed by the Governor, is as follows: Charles F. O'Donnell, M.D., Towson, representative of the Medical and Chirurgical Faculty of the State of Maryland, who was elected Chairman; Thurston R. Adams, M.D., Baltimore, representative of the School of Medicine, University of Maryland; J. Roy Guyther, M.D., of Mechanicsville, representative of the Maryland Academy of General Practice; Emily Hammond Wilson, M.D., Annapolis, and Charles H. Winnacott, M.D., Denton, two general practitioners engaged in the practice of medicine in the State of Maryland; and Nicholas C. Mueller, Baltimore, and Harry A. Dundore, Sparks, to

represent the general public.

Any report on the problems resulting from a shortage of general practitioners in Maryland would of necessity have to deal with more than the simple statement that the shortage exists. Thus, in making this study, it was felt that it was not solely the Commission's task to present statistics to corroborate the resolution's statement, but to define what this shortage means to the family in need of medical care and to project suggestions for its alleviation after careful consultation with various authorities and appropriate study.

#### First-Line Care

The Commission felt that it is important at the outset that it be understood that this shortage is a matter of first-line medical care. General practice, itself, is not declining. It is only the general practitioner who is vanishing.

The general practitioner - who might better be termed the family physician - is concerned with the total care of family health. He is health-oriented, whereas a hospital staff, for instance, is disease-oriented. The general practitioner's is as much a practice of

preventive medicine as of medicine in extremis or rehabilitative.

The family physician is not confined to specialization in only one phase of medicine, but is concerned with the whole of family well-being, mentally and physically.

In order to understand what the shrinking census of general practitioners can mean to the Maryland community, it is perhaps necessary to define exactly what a general practitioner is.

#### Four Definitions

Four authoritative sources offer the following definitions:

AMERICAN ACADEMY OF GENERAL PRACTICE: "A general practitioner is a legally qualified doctor of medicine who does not limit his practice to a particular field of medicine or surgery. In his general capacity as family physician and medical advisor, he may however devote particular attention to one or more special fields, recognizing at the same time the need for consulting with qualified specialists when the medical situation exceeds the capacities of his own training or experience."

The Academy, itself, has also approved the following defi-

inition of general practice: General (family) practice is comprehensive medical care in which the physician accepts continuing responsibility regardless of age of the patient. It is based upon integrity, continuing training, and demonstrated abilities in several medical and/or surgical disciplines. It recognizes a relationship of continuing patient management as pertains to the individual, his family, and his environment.

From the COLLEGE OF GENERAL PRACTITIONERS OF GREAT BRITAIN:

"A doctor in direct touch with patients who accepts continuing responsibility for providing or arranging their general medical care which includes the prevention and treatment of any illness or injury affecting the mind or any part of the body."

The WORLD HEALTH ORGANIZATION defines the general practitioner as: "A physician who does not limit his practice to certain disease entities and who offers his patients direct and continuing access to his services."

Even the U.S.S.R., which rarely states succinctly what it means, is the source of a definition of a general practitioner as:

"...a real family doctor who, being aware of the state of health of every member of the family, is actively helping by deed and service to improve conditions of life and work."

These then are definitions. But like most definitions they may represent only a semantic ideal. Much as he may want to be confidante, advisor and medical priest to his flock, the general practitioner is often forced by the cogency of a crowded waiting room or by a reverse ratio of supply for demand to be a first aid corpsman rather than the family physician so nobly outlined in the definitions.

#### His Key Role

Studies have been made (JAMA, July, 1963) which show that in the eyes of the public, the general practitioner continues to play the key role in medicine. He is referred to as "the front line" practitioner with the specialists backing him up.

Yet according to the numberless studies by this and various other national investigative bodies, the family physician is disappearing from the medical landscape. He is, like the buffalo or the whooping crane, becoming extinct and not much is being done about it.

The emphasis cannot be too great on the fact that there are serious gaps in Maryland in providing comprehensive medical care. As of February, 1965, there were 27 requests outstanding with the Medical and Chirurgical Faculty of Maryland for general practitioners in the State needed by both small communities who have no doctor, and by busy generalists who need associates to do their job more adequately in both small and city communities.

Where Gap Is

In other words, great advances have been made in specific areas of medical knowledge and techniques in Maryland's justly famed medical schools and teaching hospitals. Yet just a short distance away from what might be called these ivory towers, many families have difficulty obtaining the services of doctors for routine medical care. In Baltimore City alone, this produces a critical overcrowding of the emergency rooms at the hospitals.

If general practice as defined by the American Medical Association Committee on Preparation for General Practice is "that aspect of medical care performed by a doctor of medicine who assumes compre-

hensive and continuing responsibility for the patient and his family regardless of age" then general practice, as stated before, is not declining in demand in Maryland. But the qualified general practitioner is not being produced in sufficient quantity to meet this demand.

Adequate care of the ordinary illness and injury is just as important to the patient and doctor involved as are more complex problems. It is one of human nature's failings that we associate the commonplace with the distasteful.

Image Downgraded

Yet it seems to be only the public which thinks of the general practitioner as THE doctor. That image is decried by certain hospital and medical school policies in this country which tend to regard the general practitioner as of a lower rank in the medical hierarchy.

There is resistance, for instance, on the part of medical educators to the production of more general practitioners. One such medical educator (not in Maryland) is on record as stating that "any of our graduates who elects general practice has either been completely unresponsive to our instruction, has extremely bad judgment or is a fantastic egotist..."

Need Increasing

Yet figures for Maryland in the report by the Committee on Medical Care, Maryland State Planning Commission, 1962, showed that at that time of eleven communities in the State seeking medical care, nine of them specifically wanted a general practitioner. In a period of less than three years according to new figures from the Medical-Chirurgical Faculty, this has jumped to 27 general practitioners being actively sought.

Dr. Robert Farber, Commissioner of Health for the Baltimore City Health Department, in discussing the overloading of outpatient facilities of hospitals in Baltimore City as cited in a report by the Mayor's Ad Hoc Committee on Outpatient Medical Care (July, 1964) states categorically that "ONE OF THE MAIN REASONS FOR THIS OVERLOADING HAS BEEN THE SHORTAGE OF GENERAL PRACTITIONERS..." This shortage, he continued, "IS THE HEART OF THE PROBLEM OF RENDERING GOOD MEDICAL CARE IN MARYLAND."

Presidential Concern

Maryland is not alone in its demand for more general practitioners. In his February 7, 1963, health message to Congress, President

Kennedy expressed concern about a shortage of family physicians. He was explicit in stating that the health of the American people would suffer unless a threatening shortage of family physicians is corrected.

The American Academy of General Practice and the American Medical Association have been aware of this shortage since shortly after 1948. Every year since 1948 the Academy and the AMA have been receiving an increasing number of requests from communities and from family doctors for general practitioners.

For example, in 1963 the AMA Physicians' Placement Service reported that it had 793 available opportunities in communities for generalists. But only 489 general practitioners were seeking such posts.

#### Requests on Record

In Maryland currently (1965), requests have been made for generalists in the following communities by counties: Carroll County, urgent need in Union Bridge where a physician is retiring, and five or six G.P.'s declared essential elsewhere in the county by the Physicians' Procurement Committee; Garrett County, for Friendsville and surrounding area; Harford County, for Edgewood, Joppatown and surrounding area,

Norrisville and Aberdeen; for Kent County, in Chestertown; for Queen Anne's County, Church Hill and Stevensville; Somerset County, for Crisfield and for Smith Island (latter urgent); Washington County, for Hagerstown; Wicomico County, for Hebron, Nanticoke, Parsonburg and Salisbury; Prince George's County, for Hyattsville where a generalist is leaving to go into a specialty and wants a G.P. to take over his practice; Anne Arundel County, for the Annapolis suburb; Charles County, in Hughesville to replace a retired physician, and for LaPlata; Caroline County, for Denton; Worcester County for Ocean City where a desperate summer need exists for a general practitioner; and for Baltimore City, a physician no longer able to make house calls is seeking an associate G.P. to take over part of his 18-year practice, and another generalist needed for a medical center group.

#### In Public's Mind

In 1961, the Opinion Research Corporation conducted a survey for the American Academy of General Practice. The results showed that three-fourths of the public call for their family doctor first when they need help, and they feel that good medical care is centered around a

particular family physician. The other one-fourth has no family physician and these are the patients who end up in the overloaded accident rooms of the hospitals.

In 1962 the American College of Surgeons conducted a poll of its members with about 70 per cent participating. The members were asked about the distribution of specialists in their communities. The majority thought there were too many surgeons but stated their communities needed more general practitioners.

But Left Hand...

It may be that the shortage of general practitioners is like the weather; everyone talks about it, and no one does anything about it. For despite the fact that when the public thinks of doctors it is thinking usually of the family physician, the government continues to subsidize through the use of tax monies measures which deliberately continue this erosion of the general practice corps.

For instance there is a federal subsidy which underwrites at a cost of \$12,000. annually for three years the training of a psychiatrist who agrees to leave his current field of practice. Since he must

have had five years of general practice, the attrition continues in the already shrinking rolls of general practitioners.

Through the Hill-Burton Act, tax monies are used to construct hospitals and provide more hospital beds. Yet these same hospitals once constructed may adopt a policy that the general practitioner has no privileges there and may not admit his patients unless he transfers their care to a specialist.

#### On Hospital Privileges

The American Medical Association at its House of Delegates session in December, 1964, discussed a resolution that the Joint Commission on Accreditation of Hospitals should be commended for publicizing its statement that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should have granted to them such hospital privileges as their training and demonstrated skills indicated."

It was admitted that arbitrary discrimination by hospitals against general practitioners and other non-specialists is more widespread than is generally believed. The AMA's Committee on Medical

Practice believes that "arbitrary discrimination by hospitals against general practitioners is creating a division within the ranks of American medicine. This is harmful to the public which American medicine serves."

What Hospital?

According to a study of hospital usage and needs (1960 - 1980) for Anne Arundel County prepared by Gilbert A. Sanford, an associate for Research and Planning of the Hospital Council of Maryland, Inc. made in 1964, the statement is made: "...Of considerable importance in establishing a new hospital or greatly enlarging an existing hospital is the availability and location of physicians. In the main, PATIENTS GO TO THE HOSPITAL WITH WHICH THEIR FAMILY PHYSICIAN IS AFFILIATED or to the hospital which he recommends..."

The public has demonstrated its support of this concept by voluntary contributions for building and maintaining community hospitals and through government funds for hospital construction at the city, county, state and federal level. The people want their doctor to have access to the community hospital and are willing to contribute funds to enable this.

In this connection it is pertinent to quote from an editorial in the Journal of the AMA which says in part:

"...It is the profession's responsibility to make sure the new physicians are qualified for hospital practice and that they have an opportunity to obtain hospital staff appointments and privileges in their community hospitals.

"The public has supported the expansion of medical schools both through voluntary contributions and taxes. The number of medical schools has increased from 77 in 1948 to 87 in 1962, and ten more are in various stages of planning. In September, 1963, President Kennedy signed into law a three-year, \$236 million plan of aid for expansion and construction of medical schools. The law also provides for loans to medical students. The American Medical Education Foundation also provides loans to medical students (\$10,000,000 by 1963) and each school has a number of scholarship and loan programs.

"Society has a continuing responsibility to support a system that will encourage the production of competent doctors. It must also provide for licensing based upon professional standards established by professional organizations. THE INDIVIDUAL, THOUGH, HAS A RESPONSIBILITY TO FIND A GOOD GENERAL PHYSICIAN TO ACT AS THE OVER-ALL HEALTH COUNSELOR TO HIS FAMILY. THE PEOPLE OF THIS COUNTRY MUST PUT A HIGH ENOUGH PRIORITY ON THE SERVICES OF GENERAL PRACTITIONERS TO ASSURE THEIR AVAILABILITY AND CONTINUED PRODUCTION."

In Baltimore City

Discrimination in granting hospital privileges to general practitioners has certainly played a large part in Baltimore City in downgrading the image of the general practitioner inasmuch as patients who go to a generalist as a family are of necessity turned over to specialists when their illnesses require hospitalization. This policy has not

yet become common in the Maryland counties outside Baltimore City and Baltimore County although it poses a distinct threat.

The initial downgrading of the general practitioner would seem to start in medical school. Both deans of Maryland's two medical schools: Dr. Thomas B. Turner of The Johns Hopkins Medical School and Dr. William S. Stone of the University of Maryland School of Medicine stated that medical school graduates matriculate as general practitioners since their curricula are aimed at a broad background in medicine. But both affirmed that a decision to go on into generalization is affected negatively by the student's fear that he cannot do everything in medicine and do it well. This is a fear which is not quelled by the educators. Therefore he specializes so as to become learned in only one branch.

Both deans agreed that attempts to institute general practice residencies after medical school graduation had been tried and had failed to attract sufficient students to be continued.

Yet Not Opposed

Yet Dean Turner in speaking of the shortage of general practitioners felt that it was an unfortunate semantic error for the family

physician to be declared "opposed" to the specialist. He viewed it as more a matter of juxtaposition, or the family physician working side by side with the specialist.

"To be in general practice," Dr. Turner said, "Is really to be a family specialist. It is not necessary to denigrate the specialties to uphold the general practitioner. But rather to upgrade the general practitioner as one of the very best of specialists."

Both deans would have the student who contemplates general practice take internal medicine specialization as the best preparation for general practice.

#### No Real Contact

Yet neither of Maryland's schools of medicine has a general medicine practitioner on its full-time faculty so that the students are unable to come into contact with generalization in medicine except in clinic practice which is neither family medicine as now constituted, nor typical of the kinds of patients who might be found in the G.P.'s office regularly.

This absence of general practitioners on the two full-time

faculties and the denial of hospital privileges to the generalist in some Baltimore hospitals combine to make the selection of general practice by medical students a declining field of choice for medical students.

Trend Away from G.P.

There has been no decline in the number of physicians per 1,000 population. But there has been a drastic reversal in the trend from family physicians to specialists. It was pointed out that Maryland stands eighth in the nation as to number of doctors but 40th in the number of general practitioners (Medical Economics, 1964). Less than a third of the entering students at the University of Maryland School of Medicine, for instance, have indicated a career choice of general practice to illustrate this decreased preference for general practice.

And it should be pointed out that the figures which make Maryland eighth as to number of doctors include in this census some 300 physicians at the National Institute of Health in Bethesda engaged only in research -- not in treating patients.

Similarly, the physicians at The Hopkins and University of Maryland who are engaged solely in research are included. This would drastically change the figures to reveal that in Maryland there are 3,186 people per general practitioner and only 1,158 persons per specialist. In other areas there are only twelve states out of the 50 that have more people per generalist than the State of Maryland. And conversely, there are only three states which have fewer persons per specialist than this State.

#### Statistics Unwieldy

It is very difficult in this respect to get statistics which agree. There may be statistics which state categorically that there are sufficient general practitioners per 1,000 members of the population, for instance. But what statistics cannot reveal is what kind of practice the practitioner practices: if he is a G.P. with a specialty, for instance, how does he distribute his time between specialty and family practice? Or whether the residents of Howard County, for instance, who would seem to be well supplied with generalists are not still traveling to Baltimore City to visit their family physicians?

Again the Reversal

To quote again from the Baltimore City Health Department's 1964 statement of problem and background data on the overloading of out-patient facilities of hospitals in Baltimore City, the figures show that in 14 years the number of doctors per 100,000 population in Maryland has presented an about-face in type of practice. In 1949, there were 97 doctors per 100,000 population. Of these, 56 were in general practice and part-time specialization, 41 were in full-time specialization. In 1963, there were 87 doctors for the 100,000 population figure; but 31 were in general practice and 56 were specialists, which represents a state-wide as well as national trend.

Health Dept. Consensus

Each of the Maryland county health departments was contacted by this Commission to determine the health officers' appraisals of the situation as it relates to the supply of general practitioners. Of the 15 out of the 20 health departments from whom replies were received, consensus was that the biggest demand is for general practitioners in the small communities. Some of the health officers replied in more detail

than others. Baltimore County is so aware of the shortage that its health department is conducting a study of the problem.

In reply to the query to the Carroll County Health Department, Dr. Donald E. Fisher, the public health physician there, states:

"...It is conceded that we need more general practitioners in Carroll County and that those we now have could be better distributed within the county...

"Recently, I was again impressed by the great importance of a good supply of well qualified general practitioners to the success of public health activities in Carroll County. Our community mental hygiene program simply could not function without general practitioners. Our clinic for children with learning and behavior disorders would quickly become isolated from the public if it were not for the general practitioners who work with such cases in their everyday activities.

Dependent on G.P.s

"There is no doubt in my mind that public health in Carroll County is remarkably dependent on our general practice medical profession. If the supply of such physicians is not locally maintained

and augmented, our public health efforts will suffer progressive attenuation, and we will lose our most important final common pathway to the people..."

Speaking for Wicomico County, Dr. Rufus S. Gardner, Jr., feels that "General Practice is not being urged sufficiently at the medical school level..." Small communities, he says, receive 19 per cent of physicians, but have 45 per cent of the population. In 1960, there were 13 known openings for MD's in practice, with nine in general practice. He admits that rural practice in communities of 5,000 or less is not inviting to the new general practitioner, yet it is in these very areas where the greatest shortage exists.

#### Need Corroborated

In Frederick County, Dr. Forbes H. Burgess says "there is need for general practitioners in practically all of the eastern section of Frederick County. Most of this section is so sparsely populated that physicians would be unable to make a decent living. (The latest population figure for Frederick City in 1964 was 23,500, and for the whole County, 76,000.)

Dr. D. Crosby Greene, deputy state and county health officer for Washington County, says that according to the Washington County Medical Society executive secretary, "they are badly in need of at least 5 or 6 more general practitioners." The county population is put at 95,000, with two-thirds of this population within five miles of Hagerstown and two-thirds of the general practitioners located in Hagerstown.

"So far," Dr. Greene says, "vigorous efforts on the part of the Medical Society have produced no results in recruiting general practitioners."

#### Most Comprehensive

As might be expected, the most comprehensive analysis of the situation came from Dr. Perry Prather, now retired but then State Commissioner of Health. He attributes the decline in general practitioners to two factors: "The fundamental change in medical practice, and the problems of distribution of physicians to areas - especially rural areas - where there is less economic incentive, less professional stimulation and less opportunity for the intellectual and scientific environment necessary to develop and transmit medical knowledge".

Figures On Change

The change in medical practice in general, in his opinion, is characterized by the great growth of specialization. "In 1931, only one out of six physicians was a specialist. By 1940, this had risen to a ratio of one in four, and by 1962, two out of every four physicians was a specialist." However, he maintains as did the Committee on Medical Care, Medical State Planning Commission in its report of 1962, that "reported shortages of physicians...are the result of distribution problems rather than of gross shortage of physicians..."

In dealing with the problem of distribution of physicians to rural areas of need, Dr. Prather is on record as feeling that the best approach is "through positive incentives rather than through a financial lure via an educational loan and a commitment by a young man at an age when he does not yet know what his intellectual and professional interests will be."

"ONE OF THE MOST IMPORTANT OF SUCH POSITIVE INCENTIVES WHICH IS APPARENTLY NOT VERY WELL DEVELOPED, IF NOT LACKING COMPLETELY, IS THE TRANSMISSION DURING THE PROCESS OF MEDICAL EDUCATION OF AN IMAGE OF

THE FAMILY PHYSICIAN AND THE GENERAL PRACTICE OF MEDICINE IN RURAL AREAS  
--- AS A CHALLENGE --- AS OF CONSIDERABLE IMPORTANCE AND AS SOMETHING OF  
GREAT DIGNITY AND OPPORTUNITY FOR SERVICE..." Dr. Prather stated.

Three Basic Incentives

Dr. Prather offered three basic incentives or aids to better physician distribution already promoted by the State Health Department as follows:

a) Creation in strategic geographic locations of modern hospitals where the young graduate can practice scientific medicine. The Hill-Burton hospital construction program has done a good deal to create such places. This of course carries the ever present danger of overbuilding, but steps have been taken to avoid this pitfall.

b) Creation of an economic base to practice medicine in an area of low socioeconomic status. The Maryland Medical Care program for the Indigent and Medically Indigent recently augmented by the M.A.A. feature has served this purpose admirably. There are a number of physicians practicing in out of the way areas whose prime basis of income is from this source and who could not possibly remain in the area were

it not for this source of income.

c) Easily available laboratory facilities to practice modern scientific medicine wherever the physician is located. The State Health Department laboratory and its nine branches have been of incalculable value in this connection since a young, well-trained physician even in remote areas is able to obtain most of the current microbiological, hematological and blood chemical determinations which are essential to practice the kind of medicine he has learned.

Back to School Image

In regard to Dr. Prather's emphasis on positive incentives leading to general practice, Dr. John M. Byers, Deputy State Health Officer for Cecil County, cites some 16 general practitioners for a population in his County of about 50,000 or a ratio of one practitioner to 3,100 persons. He says further that "...one suggestion might be to emphasize the field of general practice more intensively in medical schools with a department of general practice, perhaps... Also, certain scholarships or tuition subsidies for medical school students who would be willing to spend two years or more in a rural or urban area in general practice..."

Edward Davens, M.D., Deputy Commissioner, spoke before the Commission and emphasized the changes in present-day living which have contributed to the shortage of general practitioners such as increased urbanization of the population and other demographic changes; increased mobility of the population which allows it to seek medical aid at a greater distance but without greater time required, and the greater per capita income which results in greater demand for all sorts of medical care from urbanized citizens.

#### Long Term Care

However, he firmly emphasized his belief that there is a great need for the family physician who can provide long-term, chronic care rather than just short-term episodic medical aid. He looked on the family physician as a manager of family health over a long period of time.

Dr. Davens felt it fundamental that some residency training programs in general practice be established in medical schools, with increased emphasis on preventive and rehabilitative medicine. This he maintained would provide an enhanced image of the family physician which

is not currently being projected in the medical schools.

In this regard, another invited participant before the Commission was Dr. George Entwisle, of the Department of Preventive Medicine and Rehabilitation at the University of Maryland. He cited the decreasing number of medical students at the University choosing general practice as a medical career choice.

He submitted a chart substantiating this which showed that in a study made in 1963, out of 352 students, 24.1 per cent selected general practice as career choice as of that time. However, this choice diminished from 28.2 per cent of the freshmen planning on general practice to 18.1 per cent of the seniors. And the jump towards a specialty is reflected in the figures which show 32 per cent favoring specialty practice as freshmen, and 33.3 per cent as seniors. The attrition in both general practice and specialty practice is accounted for by the swing by those who would have a specialty practice combined with research and teaching (31.1 per cent as freshmen, and 44.4 per cent as seniors.)

#### Surgery First Choice

The field of surgery was the preferred career choice of those

who responded in each of the four years, excluding the general practitioner on whom no inquiry was made when defining specific specialty choices. But internal medicine picked up some four per cent in preference over the four years of medical schooling.

In presenting these figures and in summarizing the discussion in which he participated with the Commission, Dr. Entwisle indicated that he had some experience with "...a pseudo-preceptorship as part of a summer fellowship program where we obtained some data on the pattern of practice in Maryland. This summer project involved the assignment of half a dozen medical students to general practitioners in Maryland, and the collection of a significant amount of data. This project was done with the cooperation of the Maryland Academy of General Practice, and these students received financial support from a training grant to this Department...

#### Elective Preceptorships

"I feel that preceptorships, on an elective basis, may be a useful experience for medical students. As I mentioned, I do not personally feel that preceptorships should be required of all students. The

only elective periods available at this school (University of Maryland) for such preceptorships is in the summer months, since the medical students do not have during the clinical years, a block of time for such an elective.

Should be Tested

"I gathered...that there was a distinct impression that preceptorships could serve as a useful recruiting device for medical students in the area of general practice. I did indicate that I was convinced that faculty members can influence career choice, but it may be that a well organized elective preceptorship program could influence career choice of medical students for general practice. I know of no study which indicates with appropriate data that this is indeed the case. However, as a hypothesis, this can and should be tested. A medical school can serve a useful function here and assist in the design and planning of a study to test this hypothesis.

"...I would strongly suggest that the objectives of such preceptorships be clearly spelled out and appropriate studies done to see if preceptorships, if they are developed, do fulfill the objectives as

indicated. The development of preceptorships would represent a change in the curricular experience of some medical students, and it would be important to gather appropriate data from its inception for an adequate appraisal of such a development."

Clinical Clerks?

Dean Stone, of the University of Maryland School of Medicine, in summarizing comments made before the Commission stated in part:

"...The family physician of the future will probably be the internist and the pediatrician. In broadening the scope of the internist practice and outlook on the practice of medicine, it may be helpful to, on an elective basis, expose medical students as clinical clerks in their fourth year of medical school to periods of family practice as carried out by selected family physicians of outstanding competence.

"This could best be done," Dean Stone continues, "if there were available fellowships to support the student during the summer period between the third and fourth years. These fellowships should be in the neighborhood of \$600. to \$800. at the present time. Most Medical students have considerable difficulty in financing their education and

have to use the summer periods for gainful employment. A fellowship of \$800. for a summer clinical clerkship with a family physician should be of real assistance in helping the medical student to decide on an area of practice."

Or Summer Fellowships

Dean Turner, of the Johns Hopkins University School of Medicine, while questioning that there is "in fact now a shortage of medical practitioners in Maryland...It is undoubtedly true that many families have difficulty in getting and keeping a family physician, but somehow I think this is more due to poor organization of the available medical facilities than to actual deficiency in numbers..." does state that a better insight into the opportunities and rewards of family practice would be provided if "the State of Maryland make available a number of summer fellowships for medical students to work with family physicians in Maryland. These fellowships should be at a financial level which would attract such students, and should probably be administered through the two medical schools since they are in the best position to recruit students..."

Because of the emphasis laid on the preceptorship program, some

definition of such a program should be made at this point. The most authoritative diagnosis of the program comes from the Commission on Education of the American Academy of General Practice as adopted at the annual meeting of the Congress of Delegates in April, 1964.

#### Aims

The purposes of these preceptorships are outlined as follows:

(a) To give insight into a medical way of life of a general practitioner in private practice in a community and to demonstrate what family practice is like, the scope of the family physician's work and the problems encountered.

1. To clarify for the student the physician's place in society, his social and civic obligations and his responsibilities to his patients.

2. To help the student grasp more fully the individual nature of private practice and the need for and the possibility of understanding each patient in relationship to his family, his job, and his total environment.

(b) The preceptorship will provide a brief period away from

the medical school during which time the students can develop some mature ideas concerning their own values and goals. This is a time when the students can contemplate the physician's place in society, as well as his social and civic responsibilities, and his responsibilities to his profession. The preceptorship permits each student to participate almost totally in a "medical way of life" with a dedicated physician carefully selected by the school.

#### Essentials of Program

A preceptorship program should include the following essentials:

(a) Ideally the program should be an integral part of the medical school curriculum.

(b) The administration of the program should be under a preceptorship committee of the faculty. At least one of the members of the committee should be a preceptor. The committee should be directly responsible to the dean of the school.

(c) The location of the preceptorship and the preceptors should be selected by the committee with the approval of the dean. The preceptors should receive a faculty appointment.

(d) The preceptorship period should be at least four weeks long and should be a required period during the junior or senior year.

(e) Preceptors should be required to evaluate the preceptee similar to other faculty members.

(f) The student should be required to submit a written report on his experience during the preceptorship.

(g) The preceptor should provide maintenance for the student, but no other remuneration.

(h) The preceptor should treat the student as a colleague but make sure the patients are informed that the preceptee is a medical student studying under the guidance of an off-campus faculty member.

(i) The student must not be relegated to the functions of a clinical clerk in the hospital or an assistant to other physicians, nor permitted to practice medicine except under the supervision of the preceptor. The student must not be left alone to cover for his preceptor even for busy periods.

(j) It should be the responsibility of the preceptorship committee to formally present the value of the preceptorship program to

the entire student body during their sophomore and junior years.

### Methods

No standard technique is prescribed because each preceptor adopts the most effective style of teaching compatible with his own personality and the individual needs of each student.

However, some generally useful techniques are:

(a) The student should be treated as an individual and as a colleague. It may be desirable to call him "doctor" but no attempt is made to hide the fact that he is a "student doctor."

(b) The student should be expected to make day and night calls and hospital rounds with the preceptor and to participate in the office routine. He should not be occupied as a clinical clerk, as assistant in surgery for other physicians in the neighborhood or as a laboratory assistant.

(c) The student should be given some definite responsibility for patient care after he is oriented. His responsibility should be increased as circumstances warrant, but he should never practice medicine without the preceptor's supervision. All of the student's notes

and recommendations must be checked and signed by the preceptor.

(d) Financial consideration shall be left to the discretion of the preceptorship committee. However, as a guide, it is suggested that students be financially responsible for their own transportation to and from the preceptor's town. The physician, in turn, should be responsible for the student's board, room and laundry during the preceptorship term.

(e) Students should not be permitted to accept payment from the preceptors for services rendered, nor can they be permitted to take a preceptor's practice while the latter is on vacation or otherwise absent.

(f) Students shall accompany preceptor on any activity such as attendance at postgraduate seminars, county medical society meetings and other medical meetings and hospital staff conferences.

So far as Maryland is concerned, such a preceptorship program would preferably be administered with the cooperation of the Maryland Academy of General Practice.

To Gain Exposure

Purpose of such a preceptorship program, as well as the other recommendations made by this Commission, is to effect exposure of medical students to qualified general practitioners during their training period. This is recommended with the positive conviction that such exposure will favorably influence some in their career choice. Unless drastic steps are taken to reverse the present trend of denigration of the family physician, general practice as a concept will disappear.

Primary Objective

It is recognized that it is not possible to legislate state-supported medical schools into "producing more general practitioners" any more than it is possible to legislate morals. But if this report accomplishes nothing else, it is hoped that the State Board of Regents and officials of the University of Maryland School of Medicine will institute a large preceptorship program in General Practice as soon as possible in the academic curriculum.

Maryland would not be initiating a new program in this respect, for some 40 medical schools in the country already have such pre-

ceptor programs operating in cooperation with the American Academy of General Practice, in which Maryland has an active chapter.

In 40 Schools

In fact, Maryland's failure to have such a program in either of its medical schools is noticeable by its omission. Such programs are now operating in the following medical schools:

Medical College of Alabama, Albany Medical College, University of Arkansas, Boston University, Bowman Gray School of Medicine, California College of Medicine, University of California, San Francisco; University of Colorado, Columbia University, Duke University, University of Florida, Medical College of Georgia, University of Illinois, Indiana University, State University of Iowa, University of Kansas, University of Minnesota, University of Mississippi, University of Missouri, University of Nebraska, State University of New York, Buffalo and Syracuse; University of North Carolina, University of North Dakota, University of Oklahoma, University of Oregon, University of Pennsylvania, Woman's Medical College of Pennsylvania, University of Rochester, N.Y.; Medical College of South Carolina, State University of South Dakota, Stritch

School of Medicine, Temple University, Pa.; University of Tennessee, University of Texas, Tufts University, University of Vermont, University of Washington, West Virginia University, University of Wisconsin.

More Students Needed

It should also be pointed out that in a "Report of Subcommittee on Expansion of Medical School Facilities" undertaken by a subcommittee of the Committee on Medical Care for the Planning Council for the Board of Health and Mental Hygiene of the State of Maryland (September, 1964), it was concluded the goal of graduating 240 physicians per year in Maryland by 1975 would be met if there were no attrition. This could be accomplished if the University of Maryland accepted 150-160 entering students by 1971 (this Commission would recommend the enlargement by 1969), and if the Johns Hopkins University Medical School continues to admit at least 90 students per year.

From Rural Areas

The Commission feels that inasmuch as many of the future general practitioners may come from the rural counties where they are most needed, it would strongly urge that consideration be given to admission

of a majority of such medical students from Maryland counties where qualification is on a par with those from out of state.

(This Governor's Commission, however, would also urge that consideration be given to a new medical school by 1980 under the Sinai and/or Greater Baltimore Medical Center complex.)

#### Result Not Automatic

This Commission considers such an increased matriculation of medical students as essential to meeting the shortage of general practitioners in Maryland inasmuch as an increased number of medical graduates is bound to include an increased number who would become general practitioners. However, this is not a result which can automatically be assumed unless steps are taken to improve the image of general practice among medical students when they are making medical career choices. Thus opportunities must be afforded interested students to be oriented and prepared for careers as general practitioners.

#### Medical Schools Informed

Medical schools have been informed by the American Medical Association of a resolution passed in 1963 "of the shortage of general

practitioners and request their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are practicing general practitioners ..."

In addition to the exposure of students to general practitioners by their inclusion on a full-time faculty, such favorable exposure could also be accomplished by the establishment of family care clinics in which a team of students under the supervision of a general practitioner assumes the health maintenance of an entire family. This principle was espoused by Dr. Edward Davens, Deputy State Commissioner of Health, in his appearance before the Commission.

#### Comprehensive Care Project

Such a system is currently being tried as a pioneer demonstration project in St. Paul, Minnesota, and has been developed within the framework of a large 5-hospital cooperative outpatient department for medically indigent patients.

In writing of the project, Dr. Winston R. Miller, Medical Director of the Saint Paul Medical Center where it is being tried, points out that "Some of the gargantuan public support and enthusiasm for medi-

cal research which have resulted in brilliant specialist achievements should be shifted back to the more fundamental duty of medicine: TO PROVIDE AND TEACH CONTINUING TOTAL HEALTH CARE FOR EACH PATIENT ACCORDING TO HIS BROAD INDIVIDUAL NEEDS. The need to teach comprehensive medical care has been emphasized at a few medical schools where various kinds of comprehensive clinics have been developed..."

He continues: "...It was difficult to overcome the traditional but insidious concept that the responsibilities of physician and nurse in outpatient clinics are limited to cursory treatment of remedial disease at convenient times... The need for broader education of the physician so that he will serve the patient as a human being and not as a case of a particular disease cannot be stressed too much. Effective comprehensive medical care requires an attitude of personal concern for the total health needs of each patient as though he were a close blood relative... Physicians who have served a rotating internship or a portion of their residency in a system which provides and teaches comprehensive medical care cannot but be better qualified to meet public demands for total health services in whatever branch of medicine they

choose to serve..."

This brings the Commission's thinking to another strong recommendation that: a) the two-year rotating internship be returned to medical education in Maryland; and b) for those who are attracted to general practice after this opportunity to survey the entire field of medicine, a two-year general practice residency training be made available.

#### Education's Responsibility

In view of the demonstrable need for more general practitioners in Maryland, it is the responsibility of medical education to provide a group specifically trained and oriented for that purpose. It is this group that is most likely to bring to the patient the best there is to offer and to assure that the best use is made of the specialties of medicine.

In order to assure the excellence in a revitalized general practice, it is the responsibility of medical education to expose the student to a program intended to produce an adequately trained general practitioner.

### General Practice Departments

The Commission believes that until departments of general practice can be established in our teaching institutions, the general practitioner will remain a hybrid. There are men in general practice as well as internal medicine and surgery with the teaching and administrative qualities necessary to put a general practice training program on a par with that of the specialties. What is lacking is the support of the educational establishments and of some of the profession, itself.

This Commission, therefore, proposes that General Practice residencies be made available in the Maryland hospitals approved for residency training as well as a re-institution of two year rotating internships for all, and that qualified general practitioners selected with the aid and cooperation of the Maryland Academy of General Practice be appointed to the full-time faculties of the two medical schools.

### Crux of Problem

Crux of the problem of garnering more general practitioners may well be what is the crux of most problems: financial.

The President's Commission on Heart Disease, Cancer and Stroke

issued a report in December, 1964, which states: "In the United States because of the length and excessive cost of medical training, a great proportion of medical students is drawn from upper class families --- 49 per cent from families with incomes of \$10,000. or more a year. Scholarship programs - comparable to those which attract young people to other scientific fields - would greatly broaden our pool of potential physicians for the future."

#### Full-Tuition Scholarships

It is therefore recommended by the Governor's Commission on the Shortage of General Practitioners in the State of Maryland that full-tuition scholarships be made available to medical students with the strict stipulation that they must then enter general practice in a Maryland area where there is a substantiated need for family physicians for a period of no less than three years. These scholars might well be by Senatorial appointment and known as Maryland Senatorial scholarships.

It is further recommended that state grants of no less than \$12,000. and no more than \$15,000. be made available annually for three

to five years to those general practitioners who set up practice in specific areas where a need has been shown. This stipend would have no bearing on the gross or net income of the family physician during that period, but would make it possible for him to practice and support himself and a family in an area where family care is not now adequately available to the residents.

#### Youth Agency Urged

As a final proposal, the Commission recommends the establishment by the State of Maryland of a program designed to attract young people into the health professions.

Specifically, an office of Health Professions Education should be established for the purpose of recruitment, guidance and placement of young people in health careers. This office should maintain liaison with the medical schools, State Department of Health, and State Department of Education. But it should be a distinct and separate agency. While this agency could maintain control over scholarship programs set up to broaden the source of potential physicians, its primary responsibility would be to increase the supply of general practitioners in Maryland.

Spend to Save

It should be pointed out that while the recommended scholarships and subsidies would seem to involve large expenditures, the result may well be a saving for the people of Maryland who are currently paying heavily for the dearth of general practitioners where they are needed.

Increasing specialization is certain to increase the cost of medical care for if the ordinary must, in every instance, be cared for by one whose training is extraordinary, the cost must be higher. This is true of paramedical costs as well as the practitioner's fee. Greater specialization means greater use of hospitals, laboratories and technical services of all sorts.

Dampen Cost Spiral

Even with the recommended program that involves considerably more training, general practice can continue to dampen the cost spiral. The general practitioner is relieved of the many pressures that are focused upon the specialists to pursue any complaint or finding to the extreme.

Intelligent observation based on a solid foundation of training and experience can many times avoid the tedious and prolonged investigations that do so much to skyrocket costs and stimulate the annually rising medical insurance premiums.

The Essential Ingredient

But more importantly, as stated in Senator Hughes' Resolution by which this Commission was appointed, "capable and well-trained general practitioners in adequate numbers are an essential ingredient in our system of medical care, the importance of their role in American medicine having been decreed by our social system in which the family is basic and in the common concept of preventive medicine in which comprehensiveness is the objective..."

It is, in short, just plain good medicine to do everything possible to preserve general practice for if general practice dies, it is the public as well as the medical profession who will be the losers.

PHYSICIANS IN PRIVATE PRACTICE

SECTION	NUMBER OF GPs			NUMBER OF SPECIALISTS		
	OVER 65	UNDER 65	TOTAL	OVER 65	UNDER 65	TOTAL
Allegany	2	20	22	6	45	51
Anne Arundel	1	31	32	1	63	64
Balto. County	8	43	51	2	47	49
Balto. City	86	320	406	117	1,005	1,122
Calvert	1	5	6			
Caroline	1	7	8			
Carroll	7	17	24		10	10
Cecil	2	15	17	1	3	4
Charles	2	9	11		1	1
Dorchester	1	9	10	4	6	10
Frederick	6	18	24	2	28	30
Garrett	1	7	8		2	2
Harford	4	21	25		16	16
Howard	4	11	15		4	4
Kent	4	5	9	1	3	4
Montgomery	12	118	130	19	350	369
Prince George's	7	74	81	1	58	59
Queen Anne's	2	3	5			
St. Mary's	2	12	14	1	3	4
Somerset	4	7	11		2	2
Talbot	3	7	10	4	17	21
Washington	7	24	31	4	43	47
Wicomico	3	12	15	2	48	50
Worcester	3	8	11		1	1
Total State	173	803	976	165	1,755	1,920

As of April, 1964

Number of Active Physicians in Maryland  
Per 100,000 Population

Year	Total	General Practice and Part-time Specialization	Full-Time Specialization
1963	87	31	56
1959	85	41	44
1955	89	46	43
1949	97	56	41

Source: M. Y. Pennell; Chief, Health Manpower Branch, U.S.P.H.S.

## CONCLUSIONS

on

## THE SHORTAGE OF GENERAL PRACTITIONERS IN THE STATE OF MARYLAND

I. The number of general practitioners in the State of Maryland is decreasing annually at an alarming rate. In April, 1964, there were 803 general practitioners under the age of 65 practicing in this State. There were 173 general practitioners over the age of 65 still in practice, but some of these have died or ceased practice in the interim since the last authoritative count was made.

The number of specialists on the other hand has increased three-fold in the past 15 years. There are now 1,920 specialists of all kinds in practice in Maryland, of whom only 165 are over the age of 65 years.

II. The ranks of the general practitioner cannot be expected to be increased materially under present conditions inasmuch as fewer medical students each year make general practice a medical career choice. In a study made in 1963 at the University of Maryland School of Medicine, only 18 per cent of all the students completing the four year medical course had indicated interest in general practice as a career choice.

III. General practice is not a career choice because the medical schools do virtually nothing to enhance the image of the family physician. No trained general practitioners are serving as members of the full-time faculties at either of Maryland's medical schools (The Johns Hopkins and University of Maryland). Hospital privileges are gradually being withdrawn from or not granted to general practitioners.

IV. The dropping of the rotating two-year internship has further diminished the young physician's opportunity to learn the satisfactions to be derived from comprehensive medical care.

V. No financial inducement is offered students interested in general practice to help subsidize their education in this field. Nor are subsidies available to enable the medical graduate to set up general practice in deprived areas where a general practitioner is urgently needed, but where the community may be unable to provide a satisfactory living for the first three to five years. Yet these are the very areas where the family physician may practice with the greatest personal satisfaction and become a part of the community.

VI. Only a very few medical students currently are enabled through the

cooperation of the Maryland Academy of General Practice to experience a preceptorship arrangement by which the student lives and studies for six weeks with a qualified general practitioner during the course of his medical education. Some 40 medical schools in other states have adopted such preceptorship programs with significant increase in interest in general practice on the part of the students.

VII. General practitioners are being sought in communities throughout Maryland. The Medical and Chirurgical Faculty of the State of Maryland reports almost daily urgent requests from practicing family physicians who can offer associate privileges to qualified physicians who will help alleviate the shortage in their areas. The Commission from its study and reports knows that a minimum of 200 general practitioners could be absorbed immediately and still leave room for many more.

VIII. Unless and until the vanishing ranks of the generalist are replenished, Maryland will suffer increasing demands on the emergency rooms of all hospitals -- demands which the hospitals cannot meet.

Most important, the Maryland resident eventually will find it impossible to have his everyday medical needs attended to unless he is willing to travel increasing distances to seek medical aid.

## RECOMMENDATIONS

by

THE GOVERNOR'S COMMISSION TO STUDY THE SHORTAGE OF GENERAL PRACTITIONERS  
IN MARYLAND

I. A large-scale Preceptorship program in General Practice shall be instituted by the State Board of Regents and the University of Maryland School of Medicine in the academic curriculum of the medical student. Such a Preceptorship program would be administered with the cooperation of the Maryland Academy of General Practice which would provide ample, well-qualified preceptors.

II. The number of medical students accepted by Maryland's two medical schools should be increased as much and as soon as possible. It is urged that the Board of Regents take prompt steps to enlarge the enrollment at the University of Maryland School of Medicine to 150-160 entering students by 1969, rather than 1971 as currently contemplated. The Johns Hopkins University Medical School admission of at least 90 students a year should be maintained and hopefully increased to 100-110 by 1969. The Commission feels that an increase in medical students will have a direct influence on a corresponding increase in the number of general practitioners who become available.

III. It is recommended that ten (10) full-tuition scholarships be provided by the State of Maryland to medical students with the strict stipulation that they must then enter general practice in a Maryland area where there is a substantiated need for family physicians, such a practice to be maintained in these areas for a period of no less than three years. The scholarships are recommended as being by Maryland Senatorial appointment.

IV. It is further recommended that the two-year rotating internship be re-established in all Maryland hospitals which have been approved for residency training; and that

V. Two year general practice residencies be instituted for those who are attracted to general practice after this opportunity to survey the entire field of medicine has been afforded. Qualified general practitioners selected with the aid and cooperation of the Maryland Academy of General Practice should be appointed to the full-time faculties of the two medical schools.

VI. It is further recommended that State of Maryland grants-in-aid of no less than \$12,000. and no more than \$15,000. shall be made available

annually for periods of three to five years to those general practitioners who set up practice in specific areas where a need has been shown. This stipend should not be affected by the gross or net income of the family physician during this period, and shall be a permanent program until there is no longer a shortage of general practitioners in Maryland.

VII. Finally, it is urged that the State of Maryland establish an office of Health Professions Education for the purpose of recruitment, guidance and placement of young people in health careers. This office should maintain liaison with the medical schools, State Department of Health, and State Department of Education. But it should be a distinct and separate agency. While this agency could maintain control over scholarship programs set up to broaden the source of potential physicians, its primary responsibility would be to increase the supply of general practitioners in Maryland.

